Passive smoking in New Zealand

Mr Lee's letter [1] pretends to a scientific basis it does not have. Hirayama's first publication [2] focused on cancer of the lung among nonsmoking Japanese wives and set off a flurry of criticism of the methodology – including the analysis. The analyses have been redone showing significance enhanced by improved analysis. Only someone committed to nonsense would report a p-value for the difference between the two results.

Mr Lee's criticism of the study by Helsing et al [3] makes no sense on the face of it. Controlling for 'a whole range of possibly relevant confounding factors' has as much likelihood of heightening the significance as of lowering it. The researchers found that adjusting the relative risks has in fact enhanced the significance of their findings.

Mr Lee has a greater tolerance for assessing a study as 'published' than most scientists do, as demonstrated by his tenth reference. Perhaps he gives more weight to studies of 9 subjects which unsurprisingly fail to yield significant results than most epidemiologists would. He may not, however, show so little tolerance for the epidemiological methods he exploits. Spousal smoking has, again and again, been shown to be associated with lung cancer risk [4,5,6]. The biomedical underpinning – proven studies in animals and dose-related responses in humans – relating the constituents of both sidestream and mainstream tobacco smoke to production of cancers of the lung is undisputed [7,8].

Propinquity of the non-smoker to the smoker over time rather than the concentration of single toxic substances in the ambient air determines the degree of exposure. Given the large numbers of exposed nonsmokers even a very low degree of risk has substantial impact.

Misclassification bias, a favourite theme of Mr Lee, is a two-edged criticism. As long as misreporting of exposure is as likely for cases as for controls misclassification depresses the relative risk. The risk will be overestimated only when cases whose husbands smoke deny their own actual smoking more readily than cases whose husbands do not smoke or when cases exaggerate their husbands' smoking more than controls do. Where actual exposure has been measured and compared with reported exposure the agreement has been high and the misreported exposure has not been in only one direction.

The validity of extrapolating exposure in the home to exposure at work raises other questions about indoor air. If the home setting is one where a nonsmoker can choose another room to be in than the one the smoker is in, then exposures at home would be lower than worksite exposures. In the workplace freedom to move away from the smoke source is generally denied. By extrapolating Kawachi et al [9] have probably underestimated the risk and the number of deaths attributable to passive smoking.

Common sense does more than pseudo-science can to produce credibility. The weight of the evidence is against Mr Lee and others whom the tobacco interests sponsor [10].

J Reinken, FFMS Consultants, Wellington.

1. Lee PN. Deaths from lung cancer and ischaemic heart disease due to passive smoking in New Zealand. NZ Med J 1989; 102: 448.
2. Hirayama T. Nonsmoking wives of heavy smokers have a higher risk of lung cancer: a study from Japan. Br Med J 1981; 282: 183-5.
3. Helsing KJ, Sandler DP, Comstock GW, Chee E. Heart disease in nonsmokers living with smokers. Am J Epidemiol 1988; 127: 915-22.
4. Abelin T. Current trends in the epidemiology of smoking, passive smoking and lung cancer. Schweiz Rundsch Med Prax 1989; 78: 87-92.
5. Svendsen KH, Kuller LH, Martin MJ, Ockene JK. Effects of passive smoking in the multiple risk factor intervention trial. Am J Epidemiol 1987; 126: 783-95.
6. Svendsen KH, Kuller LH. Re: 'Effects of passive smoking in the multiple risk factor intervention trial'. Am J Epidemiol 1989; 129: 226-7.
7. US Department of Health and Human Services. The health consequences of involuntary smoking: a report of the Surgeon-General. US DHHS, Washington, 1986.
8. Saracci R. Passive smoking and lung cancer. In: Zaridze DG, Peto R, eds. Tobacco: a major international health hazard. International Agency for Research on Cancer Scientific Publications No 74. IARC, Lyon, 1986.
9. Kawachi I, Pearce NE, Jackson RT. Deaths from lung cancer and ischaemic heart disease due to passive smoking in New Zealand. NZ Med J 1989; 102: 337-40.
10. Martin P. Passive smoking. NZ Med J 1987; 100: 696-7.

Cancer registration working group

We regret that Dr Hitchcock (NZ Med J 1989; 102: 419) regards our letter on cancer registration [1] as incorrect. We can only repeat what actually occurred.

Dr Hitchcock mentions a submission from the Board of Health. After two letters from the group seeking details the board finally stated:

> 'In reply to your letter of 22 October 1987 we believe there is nothing to be gained from pursuing the matters you raise in your letter. Our reference in our original letter referred to apparent breaches in the past and the need to provide effective controls.'

That is as much information on 'instances of breaches of confidentiality' as was ever received from the Board of Health despite the repeated requests from the group for information on actual instances. The board did not refer to any submission from private pathologists.

We repeat 'no individual, no doctor and no group provided the working group with information on breaches of confidentiality' [1]. The essential point is that, despite all our efforts, we could not find any substantiated evidence of an actual breach of confidentiality by the New Zealand Cancer Registry.

It should not be necessary, but it may be helpful, to emphasise that had the group been given information on any instance apparently involving a material breach of confidentiality we would have regarded this as a serious matter and sought to ensure a thorough, independent and sensitive investigation.

We would like to take this opportunity to thank the many organisations and individuals who submitted comments on our report to the Review Committee on Health Statistics. We appreciate the constructive criticisms and the general support for our proposals.

K R Cooke, Department of Preventive and Social Medicine, University of Otago Medical School, Dunedin;
A J Gray, Cancer Society of New Zealand, Wellington;
A F Burry, Department of Pathology, Christchurch Hospital, Christchurch;
R Stewart, Department of Surgery, Wellington School of Medicine, Wellington.

1. Cooke KR, Gray AJ, Burry AF, Stewart RJ. NZ Med J 1989; 102: 197.

Dietetic advice

I was interested to read the paper Children's diets: what do parents add and avoid? by Dr R P K Ford and colleague (NZ Med J 1989; 102: 443), with the analysis of advice on various food substances.

It is quite staggering to find that none of the 108 children interviewed for this article had been given dietetic advice. Over and over again we are concerned to find that general practitioners give detailed advice when they are not trained to do so. The whole question of diet and nutrition is underestimated and undervalued in the undergraduate and postgraduate curriculum.

Fortunately we have an efficient training programme for dietitians in New Zealand and, in my opinion, it is unethical and unprofessional to attempt to give patients detailed advice on diet when we have well trained and qualified colleagues available to undertake this task.

I was provoked to write such a letter because all too frequently we have people referred to hospital with complications of diabetes who have never had the opportunity to have a consultation with a dietitian, who could certainly have influenced their eating patterns.

D W Beaven, Department of Medicine, Christchurch Medical School, Christchurch.

Informed consent

I recently received a copy of the New Zealand Medical Association's revamped informed consent/request for treatment form.

It is impossible for a patient to know that he/she has received an adequate explanation of risks etc when the patient is in no position to assess this. If any aspect of the operation is withheld or overlooked the patient has no way of knowing.